**COPD Rescue Pack Supply Service – Record and consent form**

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
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| Patient’s details | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| First name |  |  |  |  | |  |  | |  | | |  |  | |  | |  | |  |  | |  |  |  |  | |  |  |  |  |
| Surname |  |  |  |  | |  |  | |  | | |  |  | |  | |  | |  |  | |  |  |  |  | |  |  |  |  |
| Address |  |  |  |  | |  |  | |  | | |  |  | |  | |  | |  |  | |  |  |  |  | |  |  |  |  |
|  |  |  |  | |  |  | |  | | |  |  | |  | |  | |  |  | |  |  |  |  | |  |  |  |  |
|  |  |  |  | |  |  | |  | | |  |  | |  | | Postcode | | | | |  |  |  |  | |  |  |  |  |
| Date of birth |  |  |  |  | |  |  | | NHS Number | | | | | | | | | |  |  | |  |  |  |  | |  |  |  |  |
| GP practice |  |  |  |  | |  |  | |  | | |  |  | |  | |  | |  |  | |  |  |  |  | |  |  |  |  |
|  |  |  |  | |  |  | |  | | |  |  | |  | |  | |  |  | |  |  |  |  | |  |  |  |  |
| Medicines supplied | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Medicine | | | | | | | | | | | | | | | | | | | | | | | | | | Tick box | | | | |
| **Corticosteroid:** Prednisolone 5mg tablets x [42 or 84 depending on what the local arrangements recommend] | | | | | | | | | | | | | | | | | | | | | | | | | |  | | | | |
| **Antibiotic (select one):** | | | | | | | | | | | | | | | | | | | | | | | | | |  | | | | |
| Amoxicillin 500mg capsules x 15 | | | | | | | | | | | | | | | | | | | | | | | | | |  | | | | |
| Doxycycline 100mg capsules x 6 | | | | | | | | | | | | | | | | | | | | | | | | | |  | | | | |
| Co-amoxiclav 500/125mg tablets x 15 | | | | | | | | | | | | | | | | | | | | | | | | | |  | | | | |
|  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Additional comments: | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Name of pharmacist authorising supply | | | | |  | | | | | | | | | | | | | | | | Pharmacy stamp | | | | | | | | | |
| Date of supply | | | | |  | | | | |  | | | | | |  | | | | |
| Date GP practice notified | | | | |  | | | | |  | | | | | |  | | | | |
| Pharmacy ODS code | | | | | F | | |  | | |  | | |  | | | |  | | |
| Patient declaration overleaf to be completed | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |

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| Patients who don’t have to pay must fill in parts 1 and 3. Those who pay must fill in parts 2 and 3. | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Part 1 | | The patient doesn’t have to pay because he/she: | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  | is under **16 years** of age | | | | | | | | | | | | | | | | | | | Pharmacy use only  Evidence not seen | | | | | | | | |
|  | is **16**, **17** or **18 and** in full-time education | | | | | | | | | | | | | | | | | | |
|  | is **60** years of age or over | | | | | | | | | | | | | | | | | | |
|  | has a valid maternity exemption certificate | | | | | | | | | | | | | | | | | | |
|  | has a valid medical exemption certificate | | | | | | | | | | | | | | | | | | |
|  | has a valid prescription pre-payment certificate | | | | | | | | | | | | | | | | | | |
|  | is named on a current HC2 charges certificate | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  | is entitled to, or named on, a valid NHS Tax Credit Exemption Certificate | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  | or his/her partner gets Income Support | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  | gets income-based Jobseeker’s Allowance | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  | gets Universal Credit | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  | gets income-related Employment and Support Allowance | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  | or his/her partner gets Pension Credit Guarantee Credit | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  | gets Employment and Support Allowance | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| I declare that the information I have given on this form is correct and complete.  I understand that if it is not, appropriate action may be taken. I confirm proper entitlement to exemption from prescription charges.  To enable the NHS to check I have a valid exemption and to prevent and detect fraud and incorrectness, I consent to the disclosure of relevant information from this form to [xxx] Clinical Commissioning Group, NHS England, the NHS Business Services Authority, the Department of Work and Pensions and Local Authorities. | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Part 2 | | I have paid | | | | £ | | | | | | | Now sign and fill in Part 3. | | | | | | | | | | | | | | | |
| Part 3 | | I am the patient  the patient’s guardian  (Cross ONE box) | | | | | | | | | | | | | | | | | | | | | | | | | | |
| I agree that the information on this form can be shared with:   * My/the patient’s GP practice to help them provide care to me/the patient * [xxx] Clinical Commissioning Group, to allow them to make sure the service is being provided properly by the pharmacy | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Signature | |  | | | | | | | | | | | | | | Date | | | | |  | | |  | |  | | |
| If different from overleaf, add your name and address below | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Name | |  |  |  |  | |  |  |  |  |  |  | |  |  | |  |  |  | | |  |  |  |  | |  |  |
| Address | |  |  |  |  | |  |  |  |  |  |  | |  |  | |  |  |  | | |  |  |  |  | |  |  |
|  |  |  |  | |  |  |  |  |  |  | | Postcode | | | |  |  | | |  |  |  |  | |  |  |